VERMONT
Department of Health
Agency of Human Services

RE: Docket # 06-013-H
Application for Conceptual Certificate of Need to create new inpatient programs to enhance psychiatric inpatient care and replace the functions currently performed by Vermont State Hospital

161. Regarding the caption in VDH response dated October 16, 2006:

VDH restated the case caption as follows in its response to questions, including a footnote (#1) as highlighted in the excerpt below. The footnote refers to page 53 of the Fletcher Allen Health Care Material Change Application for the Renaissance Project, Docket No. 03-006 – H, Statement of Decision on Application for Certificate of Need, November 20, 2003. The Department has reviewed the referenced page number and fails to see information there that is relevant or material to this CON proceeding, or that references replacing the functions currently performed by Vermont State Hospital.

Here is the caption as restated by VDH:

RE: Docket # 06-013-H

> ***Application for Conceptual Certificate of Need to create new inpatient programs to enhance psychiatric inpatient care and replace the functions currently performed by Vermont State Hospital filed on August 17, 2006, seeking a Certificate of Need (CON) to permit the Vermont Department of Health (VDH) to be authorized "to carry out feasibility analyses of multiple options and to develop detailed plans for the most feasible models" to replace the functions currently performed by Vermont State Hospital[1] and to permit VDH to "incur planning expenditures to analyze and compare the feasibility of various options for the replacement of the Vermont State Hospital".***

Please explain:

- **the purpose of the footnote**
- **how the referenced Statement of Decision relates to this case.**
- **why VDH restated the case caption**

VDH Response:

The footnote in the case caption (underlined above) is a software error that escaped detection when the VDH response document was proofread, resulting in the text showing two footnotes numbered "1." As BISHCA correctly states, Footnote number 1 references the Fletcher Allen Health Care Material Change Application for the Renaissance Project, Docket No. 03-006-H Statement of Decision on Application for Certificate of Need, November 20, 2003, P.53, which is the source of the directly

quoted second paragraph in the VDH response to BISHCA question # 1. The (correct) footnote number for this quotation is "1" and is so numbered in the response.

The quoted Statement of Decision relates to the recommendation in support of the integration of care that was advanced by the POC testimony and cited in Commissioner Crowley's decision.

It was intended that the case caption be repeated at the beginning of the VDH Response to BISHCA's Questions in conformity with the practice of identifying the Docket Number and purpose of the application in all documents relating to the Certificate of Application. The expanded statement of purpose, drawn from first paragraph of the BISHCA September 5 letter containing the first round of questions, was inserted in error. Following is the verbatim language of the caption as it appeared on the September 5, 2006 letter:

> *Application for Conceptual Certificate of Need to create new inpatient programs to enhance psychiatric inpatient care and replace the functions currently performed by Vermont State Hospital.*

162. Regarding questions 3 and 4 from the 1st set of questions dated September 5, 2006:

The applicant bears the burden of proving, by a preponderance of the evidence, that its proposed project meets the applicable CON criteria, standards, and principles. This burden of proof is not related to a burden of satisfying legislative standards for appropriations. This burden must be met in the Conceptual CON application process.

Regarding analyses to be conducted, the Department's questions recognized that the applicant may not have conducted the referenced analyses. The questions asked what the applicant's plans are to conduct the analyses with the authority that would be granted in a Conceptual CON.

Please indicate *how* the applicant will conduct the analyses, the *scope* of such analyses, and the planned *time-lines* for the analyses.

Please specify:

- **a. How and when the applicant will perform the indicated planning. Your response must include, but need to be limited to, the following:**
  - **i. what methodologies will the applicant employ,**
  - **ii. what expertise will the applicant engage,**
  - **iii. what time-lines will the applicant follow,**
  - **iv. when and how will the applicant quantify the extent to which it will create the "new community capacities" and how those capacities will reduce reliance on inpatient care,**
  - **v. will the applicant add specific human and financial resources to specific community mental health programs and/or services,**
  - **vi. how will the applicant determine how many people will be served "through residential services at the sub-acute levels of care",**
  - **vii. how will the applicant determine how many crisis stabilization beds will be added and where will they be located,**

viii. **how will the applicant determine what peer support services will be implemented,**
ix. **how will the applicant determine what housing and transportation services will be implemented,**
x. **how will the applicant determine what the components of the "system of care management" will consist of,**
xi. **how the "thorough clinical and operational planning process that includes the State's hospitals" (p. 28) will be accomplished,**
xii. **in preparation for replacing or improving VSH, how VDH plans to obtain information regarding how other states, both in terms of facilities and programs, serve their patient populations most similar in need to the patients at VSH.**
xiii. **when will the applicant list all "stand alone state run psychiatric hospitals that meet CMS accreditation standards", and include contact information for those facilities,**
xiv. **how and when will the entities' funding, staffing and governing needs and plans be determined?**

Please elaborate and explain

Please indicate how the applicant will conduct the analyses, the scope of such analyses, and the planned time-lines for the analyses.

VDH Response

VDH identified several general analyses and planning activities that we would conduct with the authority granted in a Conceptual CON in response to question 30. The general methods, scope and estimated timeframes for each of these follows. The time frames provided here are *estimates*. The estimated timeframe for the first set of activities, described as "near term milestones" in the response to question 30, is within a 12 months of the date of the approval of a Conceptual CON. The estimated timeframe for the second set of analyses, described as "further term milestones" begins 12-24 months after the date of the approval of a Conceptual CON.

A. Development of the program model for Intensive and Specialized levels of care

Methodologies:	Work group development and stakeholder review
Expertise:	Psychiatry, nursing, hospital administration, architectural
Time frame:	Within 12 months of planning CON

A work group comprised of psychiatric inpatient clinicians (psychiatry and nursing), fiscal analysts, architects, and inpatient managers will develop the concepts of operations of the new program model. The scope of this design work will include but is not limited to the following:

- clinical and demographic characteristics of the patients expected to be served
- services offered
- activities provided
- staffing, including number and type of staff positions

- configuration of the patient rooms, common areas, bathrooms, and treatment spaces, etc.
- laundry and materials management design requirements
- pharmacy, lab and IT
- food service
- medication storage and use
- communication systems and security systems
- outdoor space
- the manner in which visitors will access the facility
- infection control and safety
- medical records management and storage.

The Futures Advisory Committee, and other appropriate multi-stakeholder groups will review the draft program model and revisions will be made based on that input.

B. Outside review of the program model for consistency with accreditation standards, appropriateness for the population to be served, and cost-effectiveness.

Methodologies:	Assessment and evaluation
Expertise:	Psychiatry, nursing, hospital administration, psychiatric inpatient accreditation standards
Time Frame:	Within 12 months of planning CON

VDH will initiate an RFP process to engage the services of an independent consulting firm with experience in psychiatric inpatient programs to review the draft program model and evaluate it for consistency with relevant accreditation standards, appropriateness for the population to be served, and cost effectiveness. VDH cannot identify a more specific methodology to be used for this review at this time, however the responses to the RFP should provide VDH the opportunity to compare and evaluate different methodological approaches.

C. Cost modeling to implement the program model in both integrated and stand-alone settings, and with the proposed partners.

Methodologies:	Generally accepted cost estimating, accounting principles, stakeholder review
Expertise:	Cost estimating, inpatient cost modeling
Timeframe:	Within 12 months of planning CON

VDH will initiate an RFP process to engage the services of an independent firm experienced in cost estimating and inpatient services. It is possible that the activities described here for (C.) could be combined with the analysis described in (B.) above for a single RFP. The scope of the analysis will include a review of the estimated costs to implement the draft program model in a stand-alone facility or program and estimated costs if the program were part of an existing hospital.

The methodology used will be generally accepted cost accounting principles. VDH will consult with the Vermont Office of Vermont Health Access (OVHA) to assure congruity between this analysis and

the inpatient service costing and rate setting methods employed by OVHA. This information will ultimately be used to establish payment policy for the future service.

The results of this analysis will be shared with the Futures Advisory Committee and the fiscal committees of the legislature. That collective input will be used by the Administration to refine the cost models and to inform the development of the Phase 2 CON application.

D. Architectural work to refine the "program of space" based on the program model developed.

Methodologies:	Space programming, work group development, stakeholder review
Expertise:	Architectural, psychiatric inpatient facility design experience
Time frame:	Within 12 months of planning CON

The Vermont Department of Buildings and General Services (BGS) will arrange for architectural consulting services to refine the program of space needs based on the draft program model. Some of this work is in progress, described in the response to question 163. The consulting architects, along with BGS architects, will work closely with the work group charged to develop the concepts of operations for the draft program model and will assist VDH to integrate the feedback from the Futures Advisory Committee in a manner consistent with architectural standards for psychiatric inpatient services.

E. Assessment of feasibility of on-and off campus sites for the primary program and campus sites for the smaller capacities based on the refined architectural program of space.

Methodologies:	Site analysis, facility design,
Expertise:	Architectural, psychiatric inpatient facility design experience, construction
Time frame:	Within 12 months of planning CON

The Vermont Department of Buildings and General Services (BGS) will arrange for architectural consulting services to evaluate the feasibility of developing a facility that meets the program of space needs on different site options for the primary program. General principles of comparative site assessments from an architectural and construction view will be used. Additional analyses on the renovation requirements' of the smaller capacities at Rutland and/ or the Brattleboro Retreat will also be assessed.

F. Development of partnership agreements for construction/renovation, and management phases.

Methodologies:	Collaboration agreement negotiation and development
Expertise:	Legal, programmatic, fiscal, administrative
Time frame:	Beginning 12 – 24 months after planning CON

The scope of this work is to develop sufficient specificity to complete a Phase Two CON application. At this time, it is difficult to address the specific content and methods for this work because the partners, the required construction/renovation plans, and operational decisions have yet to be determined. The work will involve legal services on behalf of the Agency of Human Services and the BGS to structure collaboration agreements. The work will require fiscal expertise to develop final

cost, rate setting, and reimbursement procedures. Architectural and construction engineering services will be required to develop the construction plans. Additional expertise required includes but is not limited to consultants familiar with the CON application development and review process and writers and researchers.

G. Refined cost modeling for program operations and construction/renovation

Methodologies:	Generally accepted cost estimating, accounting principles, architectural design and construction engineering planning
Expertise:	Cost estimating, inpatient cost modeling
Timeframe:	Beginning 12 – 24 months after planning CON

The scope of this work is to develop sufficient specificity to complete a Phase Two CON application. At this time it is difficult to address the specific content and methods for this work because the program site(s) the required construction/renovation plans, and operational decisions have yet to be determined. The work will involve fiscal services on behalf of the Agency of Human Services and the BGS to develop cost estimates using generally accepted cost accounting principles. Architectural and construction engineering services will be required to develop the construction plans. Additional expertise required includes, but is not limited to, consultants familiar with the CON application development and review process and writers and researchers.

H. Architectural plans, site plans, and construction engineering

Methodologies:	Generally accepted architectural design and constructions engineering planning
Expertise:	Architectural, engineering
Timeframe:	Beginning 12 – 24 months after planning CON

The scope of this work is to develop sufficiently detailed plans to complete a Phase Two CON application. The Vermont Department of Buildings and General Services, in collaboration with the inpatient partner(s) – if relevant – will lead this scope of work in consultation with VDH and the Agency of Human Services. BGS will use generally accepted architectural design and construction engineering standards. The services of consulting architects and engineers will be engaged and the BGS staff (and inpatient partner(s) if relevant) will oversee the development of the architectural and site plans and the construction engineering.

I. Impact assessments including traffic studies, air pollution, waste water, and impact on the housing, human services and first responders of host communities.

Methodologies:	Generally accepted methods for traffic studies, air quality studies, waste water studies, impact assessments
Expertise:	Architectural, logistics, environmental, and engineering planning
Timeframe:	Beginning 12 – 24 months after planning CON

The scope of this work is to develop sufficiently detailed plans to complete a Phase Two CON application. The Vermont Department of Buildings and General Services will lead, with relevant partners, the process to develop plans to address the traffic, air quality and waste water requirements.

Site dependent analyses may include traffic studies, and other engineering studies to address parking, utility and waste water requirements.

The Agency of Human Services Field Service Directors, in consultation with VDH will work with local housing, human services, and emergency responders to develop an understanding of the current capacities of these systems. VDH will coordinate the development of information of the likely impact of locating new psychiatric inpatient programs in the identified host community(s) based on the experience of the current Vermont State Hospital. This will include, but not be limited to, the use of ambulance, police and other rescue services; the rate of discharge of non-area residents to the local community, and the resulting demands on the housing and human services infrastructure.

VDH response to question 162 continued

Please specify:

i. what methodologies will the applicant employ,
ii. what expertise will the applicant engage,
iii. what time-lines will the applicant follow,

Please refer to sections labeled "A through I" above for information about the methodologies, expertise, and timeframes VDH will employ to complete the planning process if granted a Conceptual CON.

iv. when and how will the applicant quantify the extent to which it will create the "new community capacities" and how those capacities will reduce reliance on inpatient care,

VDH plans to quantify the extent it creates new community capacities related to this Conceptual CON application (the Futures Project) by State Fiscal Year 2009. The current plan (The Vermont Mental Health Futures Plan: Proposal to Transform and Sustain a Comprehensive Continuum of Care for Adults with Mental Illness presented to the Legislative Mental Health Oversight Committee March 22 and amended April 25, 2006) calls for the phased development of the community capacities throughout FY 07 and FY 08. Realistically, VDH expects it may take longer than FY 08 to fully develop these community services.

VDH, in partnership with the Designated Community Agencies, will implement as much new "capacity" as is possible within available resources.

The question of quantifying the impact of new community resources on reducing inpatient care is difficult to answer. VDH is not aware of any precise methodology for predicting the impact of community programs on inpatient use in behavioral health care. The Vermont Mental Health Division and the Designated Agency network of providers has previous experience which indicates that the development of new community resources (residential, community supports, crisis stabilization service, rehabilitation services) does reduce Vermonters' reliance on psychiatric inpatient care. We have, however, no established methodology to quantify the impacts of this.

v. will the applicant add specific human and financial resources to specific community mental health programs and/or services,

To the extent that the Vermont Legislature appropriates funds, VDH is committed to adding the specific program capacities to the Designated Agency mental health programs that are detailed in the Futures Plan (see reference above). In addition, the VDH and the AHS continue to support the maintenance and expansion (when resources allow) of the Designated Agency provider system in general.

vi. how will the applicant determine how many people will be served "through residential services at the sub-acute levels of care",

To the extent that the Vermont Legislature appropriates funds, VDH intends to create a 16-bed capacity at the sub-acute level of care. This capacity may allow us to serve more than 16 individuals in any given year because we anticipate that some individuals will be able to transition from the community residential recovery program at the sub-acute level of care to the already established services system. The determination of how many people will be served, in a given year, will be ultimately based on the clinical needs and individual treatment plans of the residents of this program.

vii. how will the applicant determine how many crisis stabilization beds will be added and where will they be located,

To the extent that the Vermont Legislature appropriates funds, VDH intends to fully implement the proposed 10 crisis stabilization beds based on the actual costs for these programs and available appropriations. A subcommittee workgroup of the Futures Advisory Committee has developed recommendations about where the new crisis beds could be located to have the greatest impact on community need. The work group recommendations, under consideration by the VDH, include:

1. Add at least two crisis beds within each Designated Agency catchment area that does not currently have one as well as additional beds as needed to meet access recommendations and locally identified capacity needs. Criteria for the phase-in of crisis beds in the plan should consider:

    a) Geographic access data indicates highest priority locations in the corridors between White River Junction and north, and between Burlington and Bennington;
    b) Agencies most prepared to develop a program on an immediate time frame.

VDH plans to ultimately determine where to develop new crisis beds in consultation with the Designated Agency provider system, and informed by the recommendations of the mental health stakeholder community and the opportunities and feasibility of options identified by the DA provider network.

viii. how will the applicant determine what peer support services will be implemented,

Through the Futures Advisory Committee, VDH plans to staff a work group of peers and other mental health stakeholders charged to develop recommendations for consideration about what type of peer support services should be implemented and how these should be developed. The work group plans to report its recommendations to the full Futures Advisory Committee which will in turn, make recommendations to the Secretary of the Agency of Human Services. VDH plans to ultimately determine what new peer support services will be implemented in consultation with the Vermont Psychiatric Survivors, informed by the recommendations of the mental health stakeholder community and the opportunities and feasibility of options identified by the peer community.

ix. how will the applicant determine what housing and transportation services will be implemented,

With regard to housing, a work group of the Futures Advisory Committee has developed a series of recommendations which include (but is not limited to) expanded resources for rental assistance subsidies and the creation of a housing development fund. The Futures Advisory Committee refined these recommendations for the AHS Secretary at the October 2006 committee meeting. VDH plans to ultimately determine what new housing services will be implemented in consultation with the AHS Housing and Transportation Coordinator, informed by the recommendations of the mental health stakeholder community and the opportunities and feasibility of options identified by the housing and not-for-profit housing development community, within appropriated resources.

The first priority for additional transportation services is to pilot and develop alternatives to transportation to involuntary care via Sheriff. VDH has a statutory obligation (18 V.S.A. §7511) to:

> (a) . . . ensure that all reasonable and appropriate efforts consistent with public safety are made to transport or escort a person subject to this chapter to and from any inpatient setting, including escorts within a designated hospital or the Vermont state hospital, in a manner which:
> (1) prevents physical and psychological trauma;
> (2) respects the privacy of the individual; and
> (3) represents the least restrictive means necessary for the safety of the patient.

VDH plans work with the Designated Agency service providers, the AHS Housing and Transportation Coordinator, and the mental health stakeholder community to develop and refine transportation protocols and options.

x. how will the applicant determine what the components of the "system of care management" will consist of,

The Futures care management work group has internally recommended that the components of the "system of care management "include the following:

- any new capacities (inpatient, residential, and crisis bed) created under the auspices of the Futures plan
- the existing 19 Designated Agency operated crisis beds, and
- the existing general hospital psychiatric beds, and
- under consideration, is the array of Designated Agency staffed group residential treatment beds.

This recommendation has not been forwarded to the Futures Advisory Committee and as such, is preliminary. Ultimately, the VDH seeks to include as many components of the mental health acute treatment system as possible.

xi. how the "thorough clinical and operational planning process that includes the State's hospitals" (p. 28) will be accomplished,

VDH seeks to fulfill this H-RAP standard via the existing overall planning mechanisms which include formal representation of all of Vermont's psychiatric inpatient programs and the Vermont Association of Hospitals and Health Services on the Futures Advisory Committee. This committee meets monthly to assist VDH in planning this project. In addition, Vermont's hospitals are represented on the relevant work groups that develop focused programmatic recommendations. These work groups meet monthly or more frequently. As the inpatient partners are specifically identified, they will join VDH and BGS in the planning activities and analyses described above.

xii. in preparation for replacing or improving VSH, how VDH plans to obtain information regarding how other states, both in terms of facilities and programs, serve their patient populations most similar in need to the patients at VSH.

VDH plans to employ two general approaches to obtaining information regarding the experience of other states. First, VDH will use its membership in the National Association of State Mental Health Program Directors (NASMHPD) to network with our sister states. NASMHPD is the organization representing the state mental health authorities of the states and US territories. NASMHPD maintains a website designed to facilitate members' access to each other, conducts and publishes a regular survey of the "Profiles" of the fifty states, and offers research results and technical assistance.

In addition, where relevant, VDH plans to include research about other state facilities and programs in the scope of work for consulting services outlined earlier in the response to this question.

xiii. when will the applicant list all "stand alone state run psychiatric hospitals that meet CMS accreditation standards", and include contact information for those facilities,

VDH will research the best source for this information, beginning with NASMHPD and the Centers for Medicare and Medicaid Services. If such a list is readily available, we will supply it to BISHCA as soon as we get it. If such a list is not readily available and fulfilling this request requires Futures staff to do a state-by-state survey we estimate that we can supply the list and contact information to BISHCA by March 31, 2007.

xiv. how and when will the entities' funding, staffing and governing needs and plans be determined?

The staffing model for the intensive and specialized levels of care will be developed by the work group charged to design the program model within one year of the granting of a Conceptual CON. This model will be refined by the stakeholder input and consulting process described in "B" above. The

funding needs for the new services will be based on the development of cost models within the first year of the granting of a Conceptual CON and refined during the subsequent 18 months. An independent cost estimator will be used as described in "C" and "G" above. The governing needs will be determined once the partner(s) are clearly identified. The likely partners (FAHC, Rutland Regional Medical Center, and Retreat Healthcare) all have established governance mechanisms and the specific governance needs for new psychiatric inpatient programs will be identified and resolved during the negotiation of the specific collaboration agreements described in "F" above.

163. Regarding question 105:

With respect to the three FAHC options identified in the application, please indicate estimates of any and all planning, development or similar costs VDH has been asked to pay and/or expects to pay on behalf of FAHC, Rutland Regional Medical Center, and Retreat Healthcare, including but not limited to:

- **infrastructure**
- **services**
- **operations**
- **planning**
- **administration**
- **indirect costs**
- **architectural services**
- **engineering services**
- **other**

Please also provide a breakdown of all costs already incurred with respect to the development of this proposal and the application.

What is the total anticipated budget with respect to this obligation?

Please submit a copy of any and all written understandings and/or agreements pertaining to these arrangements.

Please respond separately with respect to each of the three institutions.

VDH Response

A single contract for programming, site evaluation, and preliminary design services for the primary and smaller inpatient capacities was executed with an architectural firm, called Architecture Plus. The contract was competitively bid. The scope of work includes assisting BGS and AHS in the development of plans and estimates for the new inpatient facilities to replace the Vermont State Hospital at FAHC, Rutland Regional Hospital and Retreat HealthCare. The amount of the contract is $230,000.

To date we have spent the following portions of our Contract with Architecture Plus:

Programming	$ 85,951.00
Site Evaluation	$ 38,152.50
Schematic Design	$ 40,650.00
Reimbursables	$ 8,218.79
Total	$172,972.29

Additionally, a contract has been executed with Fletcher Allen Health Care (FAHC) in the amount of $45,000 to provide reimbursement to FAHC for expenses incurred in development of feasibility analysis in support of the State's evaluation of the new inpatient site options at Fletcher Allen's MCHV Burlington Campus. No expenditures or payments have been made on this Contract to date.

No contracts have been executed with Rutland Regional Hospital or Retreat HealthCare.

Copies of the Contract between BGS and Architecture Plus and the Contract with FAHC are attached in Appendix A. These are the only agreements executed to date.

The estimate of anticipated expenses for future planning and development costs is itemized as requested in the following question, # 164.

164. Regarding question 30:

Prior to the application being ruled complete, the applicant needs to present a proposed and sufficiently detailed budget for expenses VDH anticipates incurring in preparation for filing the Phase II CON application, indicating expenditures by category. Please provide.

VDH Response

VDH and BGS expect to incur expenses for filing a Phase II CON application in two broad categories: architectural / construction planning and program development. Estimates in these categories follow.

Architectural / Construction Planning

Estimates have been acquired for any and all planning, development, and similar costs expected to be incurred by the VDH and BGS. These estimates are included in the following table however; they have been itemized by the task as indicated rather than by the type of service. Accordingly, the estimates include anticipated fees to provide Architectural and Engineering Services to study and develop options in response to infrastructure, services, operations, and planning costs associated with the development of the new inpatient facilities. Additionally, administration and indirect costs estimates anticipated by VDH and BGS usually are approximately 25% of the proposed contract price.

Vermont State Hospital Replacement Project
Potential Fee Costs Associated with Advancing the Projects through the CON Process and Design Development Phase

	Design and Development Steps	Rutland	Brattleboro	Burlington 1	Burlington 2	Burlington 3
1	Provide special analysis of the facility needs, finalize the program of space needs, adjacencies required, and determine specific requirements for coordination with the host facility.	$ 5,000	$ 4,000	$ 8,000	$ -	$ -
2	Provide planning surveys, site evaluations, and comparative studies of prospective sites.	$ -	$ -	$ 10,000	$ 10,000	$ 10,000
3	Develop Schematic Design studies illustrating the design, scale, and relationship of the project components.	$ 89,100	$ 15,000	$ 900,000	$ 90,000	$ 90,000
4	Develop and elicit ideas for consideration in developing the most energy efficient project consistent with the program intent.	$ 5,000	$ 4,000	$ 25,000	$ -	$ -
5	Prepare from approved Schematic Design Studies, the Design Development Documents to fix and describe the size and character of the project as to its site, structural, mechanical, electrical, and special systems, materials, and other essentials as appropriate.	$ 118,800	$ 20,000	$1,200,000	$ -	$ -
6	Develop special studies and analysis of environmental and project impacts, including but not limited to, storm water runoff, traffic impacts, parking needs, municipal services, and other issues to be addressed and mitigated during the permitting and construction document phases of the project.	$ -	$ -	$ 200,000	$ -	$ -
7	Determine fixtures, furnishings and equipment needs for the completed facility.	$ 10,000	$ 8,000	$ 50,000	$ -	$ -
8	Develop a statement of probable costs including construction costs, project development costs and contingencies for the completed and occupied facility	$ 10,000	$ 8,000	$ 90,000	$ -	$ -
		$ 237,900	$ 59,000	$2,483,000	$ 100,000	$ 100,000

Low Range **$1,579,900**
High Range **$2,979,900**

Taking the low and high range of the estimate and adding the previously mentioned 25% for Administration and Indirect Costs gives us a total range of:

Planning Cost Estimate - $1,975,000 to $3,725,000

The total anticipated budget for these obligations (current and anticipated expenditures) is:

Low Range – ($230,000 + $1,975,000) = $2,205,000
High Range – ($230,000 + $3,725,000) = $3,955,000

Program Development and Planning Services

VDH and AHS plans to primarily provide program development and planning services "in-kind" via the salary support for the Futures Project Team, the Office of the Attorney General, and the AHS and VDH staff contributing to the project.

The proposed partner hospitals have clearly stated that they cannot incur planning expenses outside of their current staff resources without additional support. VDH expects that the State would pay agreed upon costs for outside consultants. With regard to in-kind costs, it is assumed that the partners will assume responsibility for their respectively incurred in-kind expenditures.

VDH has executed a contract with Paulette J. Thabault, RNC, MS, JD for $23,750.00 to assist in the preparation of the Conceptual CON application and to provide consultation services throughout the application review period. VDH has currently spent $14,375 of this contractual obligation. A copy of this contract is in Appendix A.

VDH anticipates incurring planning costs for the analyses and program development activities described in the response to question 163. We do not have a specific budget for these activities at this time. We *estimate* (based on current contracts executed by AHS for other projects) that the required professional services will have an average hourly cost range of $139 - $225. We *estimate* that the cost range for program development and planning services will be $200,000 - $400,000. VDH would like to emphasize that these costs estimates are only preliminary.

165. Regarding question 8:

The Department does not clearly understand, based on the application, and written and verbal communications from the applicant, whether there is one preferred option (the 68 bed program) or three preferred options (a 40-bed stand alone psychiatric hospital on or off the Burlington campus, a 40-bed program that is physically integrated with FAHC's existing inpatient services, or a 68-bed program combining FAHC's current 28-bed program with 40 new beds physically integrated with the inpatient services).

Please provide clarification of:
a. The options that the applicant is seeking to explore within the terms of this conceptual CON. Since it is greater clarity being sought, please restate this without directly quoting the language that described the "preferred options" in the application.
b. Among the options to be explored (a), please state which, if any, are considered to be "preferred options." Please define "preferred options" in your response and please distinguish between and rank preferred options if there is more than one preferred option.

VDH Response

With regard to (a.) **The options that the applicant is seeking to explore within the terms of this conceptual CON:**

It is important for VDH to retain the opportunity to explore options that may emerge as a consequence of a comprehensive planning process.

With regard to (b): Among **the options to be explored please state the "preferred options**."

Among the specific options for the primary inpatient program listed in the application for a Conceptual CON, the rank order of preference for the primary program is:

(1) the 68 bed facility integrating the existing FAHC psychiatric inpatient program with the new inpatient services on the FAHC campus;

(2) the 40 bed facility on the FAHC campus. These two options permit programming in greatest conformity with the principle of clinical integration with hospital healthcare services and resources.

If these options do not prove feasible, VDH is seeking approval to also explore off campus options. Finally, as noted in the application, in the event of an off campus option, it may be more cost effective to locate all fifty beds at a single site.

VDH believes that the social policy aims of integration of health and mental health and the improved quality of care that such integration offers are best achieved with the on-campus options.

166. Regarding question 83:

Please provide the referenced November, 2004 report.

Please note that the second sustainability study will be required to be submitted to the Department in the Phase II review.

VDH Response

The November 2004 Report, Vermont's Designated Agency System for Mental Health, Substance Abuse & Developmental Services System Evaluation and Five-Year Projection of Service Demand and Cost Analysis, is attached (Appendix B). VDH will provide the second sustainability study to BISHCA when it is completed; we anticipate this will be in August 2007.

167. Regarding question 87:

Please provide a complete copy of the referenced Inpatient Partner Option Analysis.

VDH Response

The "Inpatient Partner Option Analysis" as it exists to date was included in the August 17, 2006 CON Application (pp 36 – 52). In reviewing the VDH response to question 87 we believe that the use of the word "summary" to describe the assessment of possible planning options has caused confusion. The response should have used the term "described." No additional material exists to augment what was contained in the Application.

168. Please use your best efforts to project the actual bed need for the full ten-year period beyond the projected opening dates of a new facility or facilities.

VDH staff have used the Milliman Actuarial Report (Appended as Attachment B to the August 17, 2006 Application) to project bed need to 2022. Please refer to Appendix C for a summary of the assumptions and the methodology underlying the table below.

Projected Average Daily Census Bed Requirements By Level of Care Extended to 2022 - Adult Mental Health Inpatient Services – Based on Milliman Actuarial Report June 2006*

Projected Scenario	**ICU Acuity ADC Bed Required**	**SIP Acuity ADC Bed Required**	**Total ICU + SIP Beds Required**	**General Psychiatric Patient ADC Bed Required**	**Total ADC All Beds Required**
Scenario One: No change in Delivery System					
2022 Need 90% Utilization	**7.71**	**62.2**	**69.8**	**130.4**	**200.3**
2016 Need 90% Utilization			65.0		
Scenario Two: Partial Implementation Community Services (50%)					
2022 Need 90% Utilization	**7.71**	**49.24**	**56..9**	**128**	**184.6**
2016 Need 90% Utilization			53		
Scenario Three: Full Implementation					
2022 Need 90% Utilization	**7.7**	**36..3**	**44.0**	**125.8**	**169.8**
2016 Need 90% Utilization			41		

Note: This table was constructed by adding the assumed 6 year impacts of population growth and mental health utilization to achieve a multiplier of 0.087 and multiplying this number by the bed capacity values presented in Table I-1, Page 6 of the Milliman Actuarial Report. See Appendix C for a discussion of the assumptions of the Milliman Report. The figures presented here are rough approximations and should be recognized as such. Given the relatively small numbers involved, the complexity of potential impacting and interacting variables and the extended time line, it is impossible to accurately estimate the error introduced by projecting these ADC numbers to 2022. **The data presented here should be regarded as ball park estimates only.**

169. What efforts have been made so far to identify a location for the secure residential treatment program? Please explain.

VDH Response

We understand that all of the components of the Futures Plan, including the plan to develop a secure residential treatment program, are *relevant* to BISCHA's review of VDH's CON application. However, we believe that the only component of the Futures Project that is subject to CON approval is the plan to construct "one or more new primary inpatient psychiatric facilities to replace existing capacity at the VSH" (quoting from VDH's Letter of Intent)."

VDH has been in dialogue with the Designated Agencies to assess their interest in providing secure residential services through face-to-face meetings with the Vermont Council of Developmental and Mental Health Service providers. Initial work with one Designated Agency included assessing the feasibility of purchasing or renting a single family unit to be renovated for this purpose or accommodating both the secure residential and a community residential recovery program at the sub-acute level of care at a single site. These initial options did not proceed to more detailed planning.

The Futures Advisory Committee, at their October 2006 meeting, accepted a recommendation to refocus and existing work group on the development of secure residential capacity. VDH will both staff this work group and again work to establish program planning and development activities for secure residential services with the Designated Agency service providers.

170. Please explain why VDH has not addressed the specific recommendation in the actuarial report concerning the development of 10 addition general psychiatric inpatient beds.

VDH Response

The Milliman actuarial study projects adult mental health inpatient bed capacity in terms of each of three implementation scenarios (pgs 49-50). In all three cases, 10 additional General Psychiatric Inpatient beds are proposed over current utilization. However, the current licensed psychiatric bed capacity of the system, as identified in the Milliman Report (p.10) and excluding current VSH capacity is 133. (Total system psychiatric bed capacity including VSH = 187.) On pp 49 and 50 the Milliman analysis of total needed system capacity, which includes the additional required 10 general psychiatric beds in each scenario, ranges from 116 to 120 beds. Thus, the system already has sufficient licensed bed capacity to meet this projected need.

171. What impact will the transfer of patients to residential recovery programs have on the census of the Vermont State Hospital? Please explain. If the estimate is too high, what effect will this have on the census at the FAHC unit?

VDH Response

VDH intends to create 16 community residential recovery beds at the sub acute level of care if adequate resources are appropriated by the legislature. This new community capacity should help to reduce the long term care patient population at VSH. The community recovery residential services may serve more than 16 individuals in any given year because we anticipate that some individuals will be able to transition from the residential recovery program to the already established outpatient community services system. Unmet needs for residential services, of any type, may have the impact of increased use of hospital care. VDH, the Designated Agencies, Vermont's hospitals and private residential providers all work to best allocate important residential resources and will continue to do so.

172. What is the capacity of the proposed VSH replacement re: high security patients? [meaning patients who present a high risk to others, or who have felony charges/convictions AND are high risk for escape] What experience does Fletcher Allen Health Care, Rutland Regional Medical Center and Retreat Healthcare have with high security patients? Will there be a separate unit or units for high security patients? What is the capacity for patients from incarceration facilities who cannot be cared for in the prison environment/need long term inpatient or residential care?

VDH Response

The proposed new inpatient programs will be designed to handle the most acute patients who present the greatest risk for security to self and others. The mechanisms to do this will include: architectural design (through use of smaller flexible unit configurations with appropriate physical security mechanisms) and program design and staffing to address the needs of patients who present high risk of elopement, self-harm or assaultive behavior toward others.

Individuals who are incarcerated need the same psychiatric service capacity as other patients with mental illness. The proposed programs will have the capacity to serve all patients regardless of legal status.

The Futures Plan proposes that the *new* inpatient capacities will serve the inpatient needs of incarcerated individuals who require special programming or intensive care. FAHC, RRMC and Retreat Healthcare currently have very limited experience with high security patients. This role has been performed by VSH. It is expected that the project design will allow for space and program configuration to safely manage these patients. Services for incarcerated individuals who require residential care are the responsibility of the Department of Corrections.

173. Regarding question 79:

Please provide a "yes" or "no" response to 79a.

VDH Response

"No." The Department of Corrections did participate in the development of the Futures Plan and is represented on the Futures Advisory Committee.

174. Regarding questions 140 to 142:

Please clarify in an answer that is responsive to this rephrased question:
The application and the answers state that the original plan called for replacement of the inpatient psychiatric beds at VSH through a combination of relocation to voluntary community residential programs and 32 involuntary inpatient beds. The answers explain that the evolution of the planning process has resulted in the replacement of the VSH inpatient beds as constituting 50 involuntary inpatient beds, and the addition of voluntary community options. This evolution would appear to require that the statement cited on page 18 of the application — that Vermont has "an important opportunity to plan for *replacement* services [to VSH] that are voluntary" — be corrected as a result of that same evolution to state that the plan will add new voluntary services, but will not *replace* current involuntary capacity with voluntary services. If this is not a correct clarification, please explain.

VDH Response

You are correct.

Material Submitted to Augment October 16, 2006 VDH Response to BISHCA September 5, 2006 Questions

BISHCA Question 21:

Please explain, with respect to the statement on page 7 regarding Springfield Hospital's status as a Critical Access Hospital (CAH), whether VDH is aware of any method, such as alternate licensing, by which inpatient psychiatric beds could be added to either the Springfield or Bellows Falls campuses (or a new campus) of Springfield Hospital in compliance with the CAH rules and/or in such a way as to permit federal financial participation despite the IMD rules. Please explain.

VDH Response October 16, 2006

We are not aware of any method by which inpatient psychiatric beds could be added to either Springfield or Bellows Falls campuses (or a new campus) of Springfield Hospital in such a way as to permit federal financial participation despite the IMD rules.

VDH Additional Information submitted November 13, 2006

Attached is a copy of a letter from Springfield Hospital dated October 24, 2006 and addressed to Acting Commissioner Moffatt (Appendix D), which VDH wishes to present for the record.

This letter references consideration of a waiver of the federal CAH ten bed DPU stipulation to permit demonstration projects providing for augmented psychiatric bed capacity up to 20 beds.

BISHCA Question 42:

42. **What are the "contemporary standards" for care referenced on page 22 under "Clinical Considerations"? Please provide the source documents.**

VDH Response October 16, 2006

The "contemporary standards" as used on p 22 refer to recommendations for reforming the delivery of mental health services. These recommendations arise from the evolution of neuroscience of mental health ---"a term that encompasses studies extending from molecular events to psychological, behavioral, and societal phenomena---" [1], The scientific basis for contemporary standards of mental health care now requires a re-conceptualization of the assumptions about, and the language used, in describing the nature of mental illness. It is no longer accurate to split "mental" from "physical" health. "We recognize that the brain is the integrator of thought, emotion, behavior, and health. Indeed, one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between "mental" and "physical" health."[2]Existing organizational structures for the delivery of mental health services reflect the outmoded science, and contribute to significant disparities in the quality of care available to psychiatric patients. This is especially true for psychiatric inpatients who have co-occurring health conditions.

Considerable work remains, however, to change historically embedded attitudes about, and fear of, people who have mental illness, and to create cultural, service and facility environments that support recovery. The President's New Freedom Commission calls for fundamental change to transform the existing system. In a transformed system 6 goals must be achieved to improve access to quality care and services:

Goal 1: Americans understand that mental health is essential to overall health;
Goal 2: Mental Health is consumer and family driven;
Goal 3: Disparities in mental health services are eliminated;
Goal 4: Early mental health screening, assessment and referral to services are common practice;

Goal 5: Excellent mental health care is delivered and research is accelerated;

[1] U.S. Department of Health and Human Services, National Institute of Mental Health, (1999). Mental Health A Report of the Surgeon General, Preface. (**Attachment 35**)
[2] Surgeon General's Report, Preface. (**Attachment 35**)

Goal 6: Technology is used to access mental health care and information.[3]

VDH Additional Information submitted November 13, 2006

Appended to this Response as Appendix E and intended to provide additional documentation in support of integration of mental health with general health services is the document, Mental Health Policy and Service Guidance Package Organization of Services for Mental Health developed by the World Health Organization in 2003. Of particular interest for this Futures Certificate of Need Application are pp. 33-45.

[3] The President's New Freedom Commission on Mental Health, Final Report (July 2003) pp 4-5.(**Attachment 36**)